NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Neuromuscular Blocking Agents: Botox/Myobloc/Dysport/Xeomin

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. What is the prescribed dosage? _____ units per _____ days
2. What is the diagnosis or indication for the medication?

Botox, Dysport, Xeomin

☐ Blepharospasm
☐ Disorders of eye movement (strabismus)
☐ Upper limb spasticity in adults
☐ Severe axillary hyperhidrosis (ANSWER QUESTIONS 2 AND 3 BELOW)
☐ Chronic anal fissure refractory to conservative treatment
☐ Esophageal achalasia recipients in whom surgical treatment is not indicated
☐ Spasticity (e.g., from multiple sclerosis, neuromyelitis optica, other demyelinating diseases of the central nervous system, spastic hemiplegia, quadriplegia, hereditary spastic paraplegia, spinal cord injury, traumatic brain injury, and stroke)
☐ Schilder's disease k. Congenital diplegia – infantile hemiplegia l. Achalasia and Cardiospasm
☐ Infantile cerebral palsy, specified or unspecified n. Hemifacial spasms o. Symptomatic (acquired) torsion dystonia
☐ Secondary focal hyperhidrosis (Frey's syndrome) q. Idiopathic (primary or genetic) torsion dystonia
☐ Laryngeal dystonia and adductor spasmodic dysphonia s. Upper limb spasticity in pediatrics t. Lower limb spasticity in pediatrics
☐ Lower limb spasticity in adults

Botox, Dysport, Myobloc, Xeomin

☐ Sialorrhea
☐ Spasmodic torticollis, secondary to cervical dystonia

3. Does the patient have documented medical complications due to hyperhidrosis? ☐ **Yes** ☐ **No Please List:** _____
4. Has the patient failed a 6-month trial of conservative management including the use of topical aluminum chloride or extra strength antiperspirant?
☐ **Yes** ☐ **No Please List product (s) tried:** _____

Botox only
Chronic Migraine (18 and older) New Therapy (approval up to 6 months):
5. Does the patient have 15 or more days each month with headache lasting 4 or more hours? ☐ **Yes** ☐ **No**
6. Has the patient tried and failed prophylactic medications from at least 3 different drug classes (beta blockers, calcium channel Blockers, tricyclic antidepressants and anticonvulsants) each for at least 3 months of therapy? ☐ **Yes** ☐ **No** List meds tried: _____
_____

Chronic Migraine Continuation of Therapy (approval up to 1 year)
7. Has the patient responded favorably after the first 2 injections? ☐ **Yes** ☐ **No**
8. Has the average number of headache days decreased by 6 or more days from the patient's baseline headache frequency? ☐ **Yes** ☐ **No**

Urinary Incontinence (Botox)
9. Does the patient have detrusor overactivity associated with neurologic conditions? ☐ **Yes** ☐ **No**
10. Has the patient tried and failed an anticholinergic medication? ☐ **Yes** ☐ **No** List med tried: _____
11. Does the patient have a documented contraindication, intolerable side effects, or allergy to anticholinergic medications? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.